

General

Guideline Title

Integration of palliative care into standard oncology care: American Society of Clinical Oncology clinical practice guideline update.

Bibliographic Source(s)

Ferrell BR, Temel JS, Temin S, Alesi ER, Balboni TA, Basch EM, Finn JI, Paice JA, Peppercorn JM, Phillips T, Stovall EL, Zimmermann C, Smith TJ. Integration of palliative care into standard oncology care: American Society of Clinical Oncology clinical practice guideline update. J Clin Oncol. 2017 Jan;35(1):96-112. [73 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Definitions for the rating of evidence (High, Intermediate, Low, Insufficient); types of recommendations (Evidence based, Formal consensus, Informal consensus, No recommendation); and strength of recommendations (Strong, Moderate, Weak) are provided at the end of the "Major Recommendations" field.

Clinical Question 1

What is the most effective way to care for patients with advanced cancer symptoms (palliative care services in addition to usual care compared with usual care alone)?

Recommendation 1: Patients with advanced cancer should be referred to interdisciplinary palliative care teams (consultation) that provide inpatient and outpatient care early in the course of disease, alongside active treatment of their cancer (Type: evidence based, benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: strong).

Clinical Question 2

What are the most practical models of palliative care? Who should deliver palliative care (external consultation, internal consultations with palliative care practitioners in the oncology practice, or

performed by the oncologist him- or herself)?

Recommendation 2: Palliative care for patients with advanced cancer should be delivered through interdisciplinary palliative care teams, with consultation available in both outpatient and inpatient settings (Type: evidence based, benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).

Clinical Question 3

How is palliative care in oncology defined or conceptualized?

Recommendation 3: Patients with advanced cancer should receive palliative care services, which may include a referral to a palliative care provider. Essential components of palliative care include: rapport and relationship building with patient and family caregivers; symptom, distress, and functional status management (e.g., pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation); exploration of understanding and education about illness and prognosis; clarification of treatment goals; assessment and support of coping needs (e.g., provision of dignity therapy); assistance with medical decision making; coordination with other care providers; and provision of referrals to other care providers as indicated. For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement, starting early in the diagnosis process and ideally within 8 weeks of diagnosis (Type: informal consensus; Evidence quality: intermediate; Strength of recommendation: moderate).

Clinical Question 4

How can palliative care services relate in practice to other existing or emerging supportive care services (including nurse navigation, lay navigation, community and home health care, geriatric oncology, psycho-oncology, and pain services)?

Recommendation 4: Among patients with cancer with high symptom burden and/or unmet physical or psychosocial needs, outpatient programs of cancer care should provide and use dedicated resources (palliative care clinicians) to deliver palliative care services to complement existing program tools (Type: informal consensus, benefits outweigh harms; Evidence quality: intermediate; Strength of recommendation: moderate).

Clinical Question 5

Which interventions are helpful for family caregivers?

Recommendation 5: For patients with early or advanced cancer for whom family caregivers will provide care in outpatient, home, or community settings, nurses, social workers, or other providers may initiate caregiver-tailored palliative care support, which could include telephone coaching, education, referrals, and face-to-face meetings. For family caregivers who may live in rural areas and/or are unable to travel to clinic and/or longer distances, telephone support may be offered (Type: evidence based; Evidence quality: low; Strength of recommendation: weak).

Clinical Question 6

Which patients should be offered or referred to palliative care services, and when in their disease trajectory; are there triggers that should be used to prompt specialty palliative care referrals?

Special Commentary: Interventional studies support early specialty palliative care referrals among patients with advanced-stage malignancies and their caregivers. However, additional triggers should be considered among all patients with cancer to ensure prompt referrals to specialty palliative care services for patients at high risk for specialty palliative care needs. Furthermore, oncologists should be educated in primary palliative care competencies and regularly assess triggers for palliative care specialty services as part of their care of patients with cancer and their family caregivers. Additional studies are needed to better define triggers for meeting unmet specialty palliative care needs in the population of patients with cancer. See the Special Commentary in the original guideline document for a discussion of the evidence

concerning referral to palliative care services.

Definitions

Guide for Rating Quality of Evidence

Rating for Strength of Evidence	Definition
High	High confidence that the available evidence reflects the true magnitude and direction of the net effect (i.e., balance of benefits versus harms) and that further research is very unlikely to change either the magnitude or direction of this net effect.
Intermediate	Moderate confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research is unlikely to alter the direction of the net effect; however, it might alter the magnitude of the net effect.
Low	Low confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research may change either the magnitude and/or direction of this net effect.
Insufficient	Evidence is insufficient to discern the true magnitude and direction of the net effect. Further research may better inform the topic. The use of the consensus opinion of experts is reasonable to inform outcomes related to the topic.

Guide for Types of Recommendations

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
Formal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. Therefore, the Expert Panel used a formal consensus process to reach this recommendation, which is considered the best current guidance for practice. The Expert Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak"). The results of the formal consensus process are summarized in the guideline and reported in the Data Supplement (see the "Availability of Companion Documents" field).
Informal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. The recommendation is considered the best current guidance for practice, based on informal consensus of the Expert Panel. The Expert Panel agreed that a formal consensus process was not necessary for reasons described in the literature review and discussion. The Expert Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak").
No recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Expert Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Guide for Strength of Recommendations

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a strong recommendation.

Rating for Strength of Recommendation	Definition
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Advanced cancer

Guideline Category

Management

Treatment

Clinical Specialty

Oncology

Intended Users

Advanced Practice Nurses

Health Care Providers

Hospitals

Nurses

Other

Patients

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Guideline Objective(s)

To provide evidence-based recommendations to oncology clinicians, patients, family and friend caregivers, and palliative care specialists to update the 2012 American Society of Clinical Oncology (ASCO) provisional clinical opinion (PCO) on the integration of palliative care into standard oncology care for all patients diagnosed with cancer

Target Population

Patients with advanced cancer and their caregivers

Note: Patients with advanced cancer are defined as those with distant metastases, late-stage disease, cancer that is life limiting, and/or with prognosis of 6 to 24 months.

Interventions and Practices Considered

1. Referral to interdisciplinary palliative care teams (consultation) that provide inpatient and outpatient care
2. Components of palliative care services
3. Timing of referral to palliative care
4. Use of dedicated resources (palliative care clinicians) to deliver palliative care services to complement existing program tools
5. Caregiver-tailored palliative care support, such as telephone coaching, education, referrals, and face-to-face meetings

Major Outcomes Considered

- Quality of life (QOL)
- Symptom relief
- Psychological outcomes
- Survival
- Satisfaction

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The recommendations were developed by an Expert Panel with multidisciplinary representation. The American Society of Clinical Oncology (ASCO) guidelines staff supplemented and updated the literature search that was conducted to inform its recommendations on palliative care. PubMed was searched from March 2010 to January 2016. The panel based its recommendations on phase III randomized controlled trials (RCTs), secondary analyses of RCTs discussed in 2012, and clinical experience. In some selected cases where evidence was lacking, but there was a high level of agreement among Expert Panel members, informal consensus was used. Articles were selected for inclusion in the systematic review of the evidence based on the following criteria: the population discussed in the articles was patients diagnosed with cancer, and articles were fully published English-language reports of phase III RCTs or

published secondary analyses of RCTs in the 2012 provisional clinical option (PCO), rigorously conducted systematic reviews, or meta-analyses.

Articles were excluded from the systematic review if they were: meeting abstracts not subsequently published in peer-reviewed journals; editorials, commentaries, letters, news articles, case reports, or narrative reviews; or published in a non-English language.

Literature Search Strategy

PubMed and the Cochrane Collaboration Library electronic databases (\pm meeting abstracts) were searched for evidence reporting on outcomes of interest.

Details of the literature search strategy are provided in Data Supplements 3 and 4 (see the "Availability of Companion Documents" field). A Quality of Reporting of Meta-analyses (QUOROM) Diagram illustrating the article selection process is available in Data Supplement 4.

Number of Source Documents

A total of nine new randomized controlled trials (RCTs), two publications reporting on one large quasiexperimental trial, and five secondary publications based on prior published RCTs met eligibility criteria and/or were suggested by the Expert Panel and form the evidentiary basis for the guideline recommendations.

See the Quality of Reporting of Meta-analyses (QUOROM) Diagram (Data Supplement 4) in the Data Supplement (see the "Availability of Companion Documents" field) for an outline of the study selection process.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Guide for Rating Quality of Evidence

Rating for Strength of Evidence	Definition
High	High confidence that the available evidence reflects the true magnitude and direction of the net effect (i.e., balance of benefits versus harms) and that further research is very unlikely to change either the magnitude or direction of this net effect.
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Insufficient	Evidence is insufficient to discern the true magnitude and direction of the net effect. Further research may better inform the topic. The use of the consensus opinion of experts is reasonable to inform outcomes related to the topic.

Guide for Rating of Potential for Bias

Rating of Potential for Bias	Definitions for Rating Potential for Risk of Bias in Randomized Controlled Trials
Low risk	No major features in the study that risk biased results, and none of the limitations are thought to decrease the validity of the conclusions. The study avoids problems such as failure to apply true randomization, selection of a population unrepresentative of the target patients, high dropout rates, and no intention-to-treat analysis; and key study features are described clearly (including the population, setting, interventions, comparison groups, measurement of outcomes, and reasons for dropouts).
Intermediate	The study is susceptible to some bias, but flaws are not sufficient to invalidate the results. Enough of the items introduce some uncertainty about the validity of the conclusions. The study does not meet all the criteria required for a rating of good quality, but no flaw is likely to cause major bias. The study may be missing information, making it difficult to assess limitations and potential problems.
High risk	There are significant flaws that imply biases of various types that may invalidate the results. Several of the items introduce serious uncertainty about the validity of the conclusions. The study has serious errors in design, analysis, or reporting; large amounts of missing information; or discrepancies in reporting.

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Data Extraction

Literature search results were reviewed and deemed appropriate for full text review by one American Society of Clinical Oncology (ASCO) staff reviewer in consultation with the Expert Panel Co-Chairs. Data were extracted by one staff reviewer and subsequently checked for accuracy through an audit of the data by another ASCO staff member. Disagreements were resolved through discussion and consultation with the Co-Chairs if necessary. Evidence tables are provided in the original guideline document and/or in Data Supplements 1 and 2 (see the "Availability of Companion Documents" field).

Study Quality Assessment

Study quality was formally assessed for the studies identified. Design aspects related to the individual study quality were assessed by one reviewer and included factors such as blinding, allocation concealment, placebo control, intention to treat, funding sources, etc. The risk of bias is assessed as "low," "intermediate," or "high" for most of the identified evidence.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

Expert Panel Composition

The American Society of Clinical Oncology (ASCO) Clinical Practice Guidelines Committee (CPGC) convened an Expert Panel with multidisciplinary representation in palliative care, medical oncology, community oncology, oncology nursing, radiation oncology, oncology social work, thoracic oncology, and patient/advocacy representation. The Expert Panel was led by two Co-Chairs who had primary responsibility for the development and timely completion of the guideline. For this guideline product, the

Co-Chairs selected one additional member to assist in the development and review of the guideline drafts.

Guideline Development Process

The Expert Panel met on several occasions and corresponded frequently through e-mail; progress on guideline development was driven primarily by the Co-Chairs/Steering Committee along with ASCO staff. The purpose of the meetings was for members to contribute content, provide critical review, interpret evidence, and finalize the guideline recommendations based upon the consideration of the evidence. All members of the Expert Panel participated in the preparation of the draft guideline document.

Development of Recommendations

The guideline recommendations were crafted, in part, using the GuideLines Into DEcision Support (GLIDES) methodology and accompanying BRIDGE-Wiz software™. This method helps guideline expert panels systematically develop clear, translatable, and implementable recommendations using natural language, based on the evidence and assessment of its quality to increase usability for end users. The process incorporates distilling the actions involved, identifying who will carry them out, to whom, under what circumstances, and clarifying if and how end users can carry out the actions consistently. This process helps the Expert Panel focus the discussion, avoid using unnecessary and/or ambiguous language, and clearly state its intentions.

Rating Scheme for the Strength of the Recommendations

Guide for Types of Recommendations

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
Formal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. Therefore, the Expert Panel used a formal consensus process to reach this recommendation, which is considered the best current guidance for practice. The Expert Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak"). The results of the formal consensus process are summarized in the guideline and reported in the Data Supplement (see the "Availability of Companion Documents" field).
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No recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Expert Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Guide for Strength of Recommendations

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns

Rating for Strength of Recommendation	Definition
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Cost Analysis

The guideline developers reviewed published cost analyses.

Refer to "Cost Implications" for an analysis of economic impact.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Members of the Expert Panel were responsible for reviewing and approving the penultimate version of the guideline, which was then circulated for external review and submitted to *Journal of Clinical Oncology* for editorial review and consideration for publication. All American Society of Clinical Oncology (ASCO) guidelines are ultimately reviewed and approved by the Expert Panel and the ASCO Clinical Practice Guideline Committee before publication. The Clinical Practice Guidelines Committee approved the guideline on August 15, 2016.

External Review and Public Comment

The draft recommendations were released to the public for open comment from July 6 to 20, 2016. A total of 94% of the 28 respondents either agreed or agreed with slight modifications to the recommendations, whereas 6% of the respondents disagreed. Comments received were reviewed by the Expert Panel and integrated into the final draft before approval by the ASCO Clinical Practice Guideline Committee.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- There is now robust evidence from multiple large clinical trials that early palliative care improves quality of life (QOL), reduces depression, and improves satisfaction with care. Early palliative care also reduced the use of chemotherapy near end-of-life (EOL) for patients with lung cancer and increased enrollment and length of stay in hospice, while improving survival. In a quasiexperimental study in patients with lung cancer, benefits were noted primarily for patients with stage I to IIIB disease rather than stage IV disease.
- Early palliative care involvement may benefit family caregivers emotionally and psychologically by lowering levels of depression, stress, caregiver burden, and psychological distress.

Refer to the "Literature review update and analysis" and "Clinical interpretation" sections of the original guideline document for a discussion of the potential benefits of each recommendation.

Potential Harms

It is noteworthy that there were no adverse outcomes reported from early palliative care involvement in any of the trials.

Refer to the "Literature review update and analysis" and "Clinical interpretation" sections of the original guideline document for a discussion of the potential harms of each recommendation.

Qualifying Statements

Qualifying Statements

- The clinical practice guidelines and other guidance published herein are provided by the American Society of Clinical Oncology, Inc. (ASCO) to assist providers in clinical decision making. The information herein should not be relied upon as being complete or accurate, nor should it be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. With the rapid development of scientific knowledge, new evidence may emerge between the time information is developed and when it is published or read. The information is not continually updated and may not reflect the most recent evidence. The information addresses only the topics specifically identified herein and is not applicable to other interventions, diseases, or stages of disease. This information does not mandate any particular course of medical care. Further, the information is not intended to substitute for the independent professional judgment of the treating provider, because the information does not account for individual variation among patients. Recommendations reflect high, moderate, or low confidence that the recommendation reflects the net effect of a given course of action. The use of words like "must," "must not," "should," and "should not" indicates that a course of action is recommended or not recommended for either most or many patients, but there is latitude for the treating physician to select other courses of action in individual cases. In all cases, the selected course of action should be considered by the treating provider in the context of treating the individual patient. Use of the information is voluntary. ASCO provides this information on an "as is" basis and makes no warranty, express or implied, regarding the information. ASCO specifically disclaims any warranties of merchantability or fitness for a particular use or purpose. ASCO assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this information or for any errors or omissions.
- Refer to the "Health Disparities," "Multiple Chronic Conditions," "Limitations of the Research" and "Limitations of the Literature and Future Directions" sections in the original guideline document for additional qualifying information.
- This guideline uses the National Consensus Project definition of palliative care: "Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical,

intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." ASCO believes that cancer clinical trials are vital to inform medical decisions and improve cancer care and that all patients should have the opportunity to participate. Patients in clinical trials may benefit from the support of palliative care.

Implementation of the Guideline

Description of Implementation Strategy

Guideline Implementation

American Society of Clinical Oncology (ASCO) guidelines are developed for implementation across health settings. Barriers to implementation include the need to increase awareness of the guideline recommendations among front-line practitioners and patients with cancer and their caregivers, as well as the need to provide adequate services in the face of limited resources. A retrospective quality-of-care survey of caregivers found that between 2000 and 2011 to 2013, caregivers' reports of their deceased loved ones' needs for many aspects of palliative and end-of-life (EOL) care showed perceptions worsening or staying the same over time, regardless of large policy changes. The only improvement was seen in religious and spirituality needs among all respondents, and in a subanalysis of one of three survey rounds, 61% of those in hospice in their last month of life rated care as excellent versus 47% of those not in hospice. The authors conclude that opportunities for better pain management, better care for dyspnea and anxiety or depression, and better communication remain. Continued focus on implementation and quality measurement in palliative care is crucial. This guideline will be distributed widely through the ASCO Practice Guideline Implementation Network (PGIN). The guideline Bottom Line Box is designed to facilitate implementation of recommendations. ASCO guidelines are posted on the [ASCO Web site](#) and most often published in *Journal of Clinical Oncology (JCO)* and *Journal of Oncology Practice*.

For additional information on the ASCO implementation strategy, please see the [ASCO Web site](#) .

Implementation Tools

Chart Documentation/Checklists/Forms

Patient Resources

Quick Reference Guides/Physician Guides

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Ferrell BR, Temel JS, Temin S, Alesi ER, Balboni TA, Basch EM, Firn JJ, Paice JA, Peppercorn JM, Phillips T, Stovall EL, Zimmermann C, Smith TJ. Integration of palliative care into standard oncology care: American Society of Clinical Oncology clinical practice guideline update. *J Clin Oncol*. 2017 Jan;35(1):96-112. [73 references] [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 Jan

Guideline Developer(s)

American Society of Clinical Oncology - Medical Specialty Society

Source(s) of Funding

American Society of Clinical Oncology (ASCO)

Guideline Committee

Expert Panel

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Guideline and Conflicts of Interest

The Expert Panel was assembled in accordance with the American Society of Clinical Oncology (ASCO) Conflict of Interest Policy Implementation for Clinical Practice Guidelines ("Policy," found at <http://www.asco.org/rwc>). All members of the Expert Panel completed ASCO's disclosure form, which requires disclosure of financial and other interests, including relationships with commercial entities that are reasonably likely to experience direct regulatory or commercial impact as a result of promulgation of the guideline. Categories for disclosure include employment; leadership; stock or other ownership; honoraria, consulting or advisory role; speaker's bureau; research funding; patents, royalties, other intellectual property; expert testimony; travel, accommodations, expenses; and other relationships. In accordance with the Policy, the majority of the members of the panel did not disclose any relationships constituting a conflict under the Policy.

Authors' Disclosures and Potential Conflicts of Interest

The following represents disclosure information provided by authors of this manuscript. All relationships are considered compensated. Relationships are self-held unless noted. I = Immediate Family Member, Inst = My Institution. Relationships may not relate to the subject matter of this manuscript. For more information about ASCO's conflict of interest policy, please refer to www.asco.org/rwc or jco.ascopubs.org/site/ifc .

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No relationship to disclose

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No relationship to disclose

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Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the [Journal of Clinical Oncology Web site](#) .

Availability of Companion Documents

The following are available:

The integration of palliative care into standard oncology care: American Society of Clinical Oncology clinical practice guideline update. Methodology supplement. Alexandria (VA): American Society of Clinical Oncology; 2016. 18 p. Available from the [American Society of Clinical Oncology \(ASCO\) Web site](#) .

The integration of palliative care into standard oncology care: American Society of Clinical Oncology clinical practice guideline update. Data supplement. Alexandria (VA): American Society of Clinical Oncology; 2016. 36 p. Available from the [ASCO Web site](#) .

The integration of palliative care into standard oncology care: American Society of Clinical Oncology clinical practice guideline update. Slide set. Alexandria (VA): American Society of Clinical Oncology; 2016. 24 p. Available from the [ASCO Web site](#) .

The integration of palliative care into standard oncology care: American Society of Clinical Oncology clinical practice guideline update. Summary of recommendations. Alexandria (VA): American Society of Clinical Oncology; 2016. 2 p. Available from the [ASCO Web site](#) .

The integration of palliative care into standard oncology care: American Society of Clinical Oncology clinical practice guideline update. Palliative care checklist. Alexandria (VA): American Society of Clinical Oncology; 2016. 1 p. Available from the [ASCO Web site](#) .

Patient Resources

The following is available:

Palliative care - caring for the symptoms of cancer and its treatment. Patient information. 2016 Oct. Available from the [Cancer.Net Web site](#) .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

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